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ATTACHMENT A

page 1 of 18

Title: Method and System for Documenting
Patient Treatment and Evaluation by Goal or
Outcome/Progress

Inventor: T. Luttrell

Docket #: TAML-100A

Front Range Open Gait, P.C.

Fort Collins, CO

Monthly Treatment and Progress

Dates Covered: through

Patient:

Ft. Collins, CO

Physician:

Primary Therapist: T. M.S., P.T.

Primary Payer: M.

Secondary Payer:

History:

Goal Progress Toward Goal

Subjective comments

Pt ill recently, and not tolerating treatment very well today.

60 minutes Therapist: OTR

Still not feeling 100%.

60 minutes Therapist: T. M.S., P.T.

Pt very uncomfortable with significantly increased tone.

60 minutes Therapist: OTR

Re-evaluation/Clinical assessment.

Preserve range of motion at bilateral hips with stretching activities in the pool and at home per home exercise program.

Bilateral hip stretching.

60 minutes Therapist: PT

Appropriate wheel chair seating system to accommodate differences in tone since Intrathecal Baclofen pump regime.

Modify existing seating system.

Order additional components for back supports, ordered seating.

60 minutes Therapist: T. M.S., P.T.

Schedule joint appointment to do foam in place seating.

60 minutes Therapist: T. M.S., P.T.

Rehab Designs to order additional components for back to facilitate bilateral shoulder protraction.

60 minutes Therapist: T. M.S., P.T.

Tuesday, January

T

~~1. Summary~~ through ~~2. Summary~~

Goal	Progress Toward Goal
-------------	-----------------------------

Will hold reins with hands in midline for 5 minutes.

OT: Establish bilateral hand splints to decrease tone and improve hand position and function.

Pt not using hand splints due to body aches from illness. 60 minutes Therapist: Karen M. [redacted], OTR

OT: [REDACTED] 1960 bottles positive

OT: Increase active range of motion and upper extremity strength in bilateral upper extremities for improved access to communication device.

Range of motion limited today, due to pt not feeling well.
60 minutes Therapist: [REDACTED] OTR

Passive range of motion on bilateral upper extremities. Pt with increased tone today.
60 minutes Therapist: [REDACTED] OTR

PROM of bilateral extremities. Pt very sore and tight, complaining of lower back pain.
60 minutes Therapist: [REDACTED] OTR

PROM performed on bilateral upper extremities, head and trunk.
60 minutes Therapist: [REDACTED], OTR

OT: Increase volitional reach to access _____

Reaching to make choices. Is improving in accuracy to 9/10 times.

60 minutes Therapist: [REDACTED] OTR

60 minutes Therapist: [REDACTED] OTR

Rehab Potential: Good

Plan: Implement next month's goals

Continue OT/PT 1-2 times per week.

Seating- investigate alternatives to allow functional seating for more than 90 minutes without excessive pressure at IT's or coccyx. Follow up scheduled 1/6/98.

Therapist Signature: _____ Date: _____

Physician Signature: _____ Date: _____

Tuesday, January 20

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1260 Doctors Lane, Suite A

Fort Collins, CO 80524

(970) 498-9310

Monthly Goals

Dates Covered: through

Patient:

Physician:

Primary Therapist:

Occupational Therapist:

Speech Therapist:

History:

Goal/Outcome Measure

Note

Date

Achieved

Started

Inactivated

Rx

Plan:

[prescription / Rx]

instructions for (later) treatment or remedy

Physical Therapist Signature: _____

Date: _____

Saturday, December 9, 2000

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**PROGRESS EVAL*
Comparison evaluation


Title: Method and System for Documenting
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Patient:

Start Date:

End Date:

Available Tests		Selected Tests
<div></div>	<div>></div> <div>>></div> <div><</div> <div><<</div>	<div></div>



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34



Comprehensive Evaluation

Patient:

Evaluation Date:

Physician:

Primary Therapist:

Primary Payer:

Secondary Payer:

History:

Test	Description	Test Position	Tool	Data	Plane	Therapist
Lower Extremity Musculoskeletal Assessment						
Lower extremity: foot	The patient has decreased one foot balance on left compared to right: <10 sec.			/		
				/		
Trunk & Pelvic Alignment in Standing						
Lordosis						
Scoliosis						
Hip						
Abduction	Hips extended				L R1/R2: /	
					R R1/R2: /	
Extension: Staheli	Use minus sign if extension < 0 °				L Degrees:	
					R Degrees:	
Extension: Thomas	Use minus sign if extension < 0 °				L Degrees:	
					R Degrees:	

134 (continued)

Rebecca A. Luttrell

Evaluation Date:

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Title: Method and System for Documenting
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Test Description Test Position Tool Data Plane Therapist

Medial/Lateral Rotation: Hips Extended

L M/L: /

R M/L: /

Medial/Lateral Rotation: Hips Flexed

L M/L: /

R M/L: /

Knee

Flexion

Hip extended

L R1/R2: /

R R1/R2: /

MMT- Knee Extension

Varum/Valgum

Indicate use of Intramalleolar Space
(IMS) or Femoral-Tibial Angle (FTA)

L:

R:

Physical Therapist Signature:

Date:

Occupational Therapist Signature:

Date:

Speech Pathologist Signature:

Date:

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Comprehensive Evaluation

Evaluation Date:

Patient:

#Error

Physician:

Primary Therapist:

Primary Payer:

Secondary Payer:

History:

Test	Description	Tool Data		Plane	Therapist
		#Error	Date:		
Physical Therapist Signature:		#Error	Date:		
Occupational Therapist Signature:		#Error	Date:		
Speech Pathologist Signature:		#Error	Date:		

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Docket #: TAML-100A

Dates Covered: [REDACTED] though [REDACTED]

[illegible]

Patient

Primary Therapist

Last Rx

Last Plan

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-Front Range Open Gait, P.C.

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Title: Method and System for Documenting Patient Treatment and Evaluation by Goal or Outcome/Progress

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Plan Summary

Dates Covered: [redacted] through [redacted]

Patient	Plan
Patient A.M.	<p>Plan Date: [redacted] Rehab Potential: [redacted]</p> <p>Plan: [redacted]</p> <p>Plan Effective Dates [redacted] through [redacted]</p> <p>PT: [redacted] 5-8 times per month. Treatment to include direct therapeutic activities, neuromuscular re-education for continued trunk strengthening and continued gait training and [redacted]</p> <p>SP: [redacted] per week or 4-8 times per month for 12 weeks for expressive/receptive communication in the home or clinic.</p> <p>OT: Skilled OT services 1-2 times per week to address therapeutic exercise, neuromu [redacted] care management and cognitive skill development. [redacted]</p>
Patient B.M.	<p>Plan Date: [redacted] Rehab Potential: [redacted]</p> <p>Plan: [redacted]</p> <p>Plan Effective Dates [redacted] through [redacted]</p> <p>SP: Skilled speech therapy 1-2 times per week or 4-8 times per month for feeding issues, [redacted] Patient to be seen at home, clinic, or school environment. [redacted]</p>
Patient C.M.	<p>Plan Date: [redacted] Rehab Potential: [redacted]</p> <p>Plan: [redacted]</p> <p>Plan Effective Dates [redacted] through [redacted]</p> <p>PT: Patient has been on hold from aquatic therapy this past month. [redacted] Patient may be seen one time per week, 3-5 times per month if family feels it is appropriate at this time. [redacted]</p>

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Plan Summary

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Patient

Plan

Patient D.M.

Plan Date:

Rehab Potential:

Plan:

Plan Effective Dates through

SP: Patient placed on hold until next hippotherapy session; have not seen all month.

PT: Patient is finished with hippotherapy session. Contact will be made with family to discuss continued PT in home or clinic settings one time per week, 3-5 times per month. Treatment will include neuromuscular re-education, gait training, direct therapeutic activities and HEP.

Plan Date:

Rehab Potential:

Plan:

Plan Effective Dates through

PT: Patient has completed hippotherapy sessions. The patient's needs will be re-addressed and patient will be seen once a week in the home or clinic environment. Treatment will include neuromuscular re-education, gait training, direct therapeutic activities and HEP.

Plan Date:

Rehab Potential:

Plan:

Plan Effective Dates through

PT: Patient will receive PT 3 times a month in the home or clinic environment. Treatment will include neuromuscular re-education, gait training and direct therapeutic activities to further his gross motor developmental skills.

Plan Date:

Rehab Potential:

Plan:

Plan Effective Dates through

SP: Skilled speech therapy 1-3 times per week or 4-12 times per month in home, clinic, pool or school environment to increase communication skills.

OT: Skilled OT 1-2 times per week or 4-8 times per month to address therapeutic exercise/HEP, neuromuscular re-education, direct therapeutic activities, ADL self care management and cognitive skill development. Settings to include clinic and home.

Patient E.M.

Patient F.M.

Patient G.M.

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Navigation buttons: [Back] [Forward] [Home] [Search] [Print] [Exit] [Help] [Refresh] [Zoom In] [Zoom Out] [Full Screen] [Close]

Search bar: [Search]

Patients

Name: [Redacted] ☐ Active

Address: [Redacted] Sex: [Redacted]

City: [Redacted] State: [Redacted] Zip Code: [Redacted]

Phone: [Redacted] Phone 2: [Redacted]

SSN: [Redacted] Birth Date: [Redacted]

Primary Insurance: [Redacted] Group #: [Redacted] Policy #: [Redacted]

Second Insurance: [Redacted] Group #: [Redacted] Policy #: [Redacted]

Doctor: [Redacted] Therapist: [Redacted]

History

[Redacted History Box]

Navigation buttons: [Back] [Forward] [Home] [Search] [Print] [Exit] [Help] [Refresh] [Zoom In] [Zoom Out] [Full Screen] [Close]

Search bar: [Search]

Patients

Name: [Redacted] ☐ Active

Address: [Redacted] Sex: [Redacted]

City: [Redacted] State: [Redacted] Zip Code: [Redacted]

Phone: [Redacted] Phone 2: [Redacted]

SSN: [Redacted] Birth Date: [Redacted]

Primary Insurance: [Redacted] Group #: [Redacted] Policy #: [Redacted]

Second Insurance: [Redacted] Group #: [Redacted] Policy #: [Redacted]

Doctor: [Redacted] Therapist: [Redacted]

History

[Redacted History Box]

Navigation buttons: [Back] [Forward] [Home] [Search] [Print] [Exit] [Help] [Refresh] [Zoom In] [Zoom Out] [Full Screen] [Close]

Search bar: [Search]

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Therapists

Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____
 SSN: _____ License: _____

Therapists

Name: _____
 Address: _____ Doctors Lane #A
 City: Fort Collins State: CO Zip Code: _____
 Phone: _____ Fax: _____
 SSN: _____ License: _____

Therapists

Name: _____ PT
 Address: _____
 City: Fort Collins State: CO Zip Code: _____
 Phone: _____ Fax: _____
 SSN: _____ License: _____

Therapists

Name: _____
 Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone: _____ Fax: _____
 SSN: _____ License: _____

2002200 6/2/2001

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Practice

Name:

Address:

City: State: Zip Code:

Phone: Fax:

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☐ All records

Evaluations

Evaluation Date 30-Dec-2000

☐ Achieved

Patient

Therapist: [REDACTED] PT: [REDACTED]

Evaluation

Category

Test

Tool

Test Position: sitting

Plane Sagittal Plane

Note

☐ All records

Evaluations

Evaluation Date	24-Sep-2011
-----------------	-------------

☐ **Achieved**

Patient:

Therapist: ~~Tammy~~ ~~McKinnon~~ M.S., P.T.

Evaluation

Category

Test

Tool

Test Position	Unilateral Stance
---------------	-------------------

Plane Frontal Plane

Note

☐ All records

Evaluations

Evaluation Date: 21-D

☐ **Achieved**

Patient

Therapist: [REDACTED] PT

Evaluation

Category

Tes

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Categories

Evaluation: Amputee/Prosthetic evaluation

Category: Patient History

Sort Order: 1



Categories

Evaluation: Amputee/Prosthetic evaluation

Category: Clinical Findings

Sort Order: 1



Categories

Evaluation: Amputee/Prosthetic evaluation

Category: Subjective

Sort Order: 2



Categories

Evaluation: Amputee/Prosthetic evaluation

Category: Mental Status

Sort Order: 3



Categories

Evaluation: Amputee/Prosthetic evaluation

Category: Pain

Sort Order: 4



Categories

Evaluation: Functional Profile - Lower Extremity

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Tests

Evaluation: Amputee/Prosthetic evaluation

Category: Clinical Findings

Test: _____

Description: _____

Data Label: _____

☐ Two Values

☐ Left/Right

Tools: Please select the valid tool choices for this test.

AF	Angle Finder
BPG	Biplane Goniometer
MMT	Manual Muscle Test
Ruler	Ruler
Time	Stop Watch
UG	Universal Goniometer

Tests

Evaluation: Functional Profile - Lower Extremity

Category: Excursion Tests

Test: _____

Description: _____

Data Label: _____

☐ Two Values

☐ Left/Right

Tools: Please select the valid tool choices for this test.

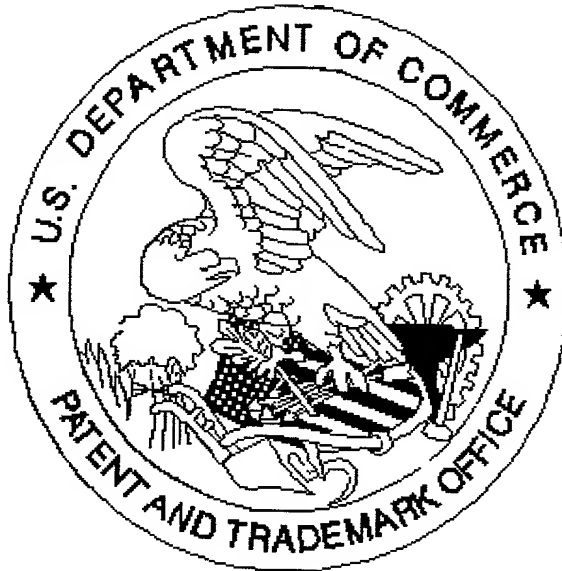
AF	Angle Finder
BPG	Biplane Goniometer
MMT	Manual Muscle Test
Ruler	Ruler
Time	Stop Watch
UG	Universal Goniometer

Tests

Evaluation: Lower Extremity Musculoskeletal Assessment

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for scanning. (Document title)

☐ Page(s) _____ of _____ were not present
for scanning. (Document title)

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